ACUPUNCTURE CONTINUUM

CONFIDENTIAL CASE HISTORY

This is a CONFIDENTIAL health profile to help us determine the best treatment plan for you. If you have any questions, please ask.

Date _____

Patient Information

Name _____ Soc. Sec. #_____
LAST NAME FIRST NAME MIDDLE INITIAL

Address _____

City _____ State_____ Zip_____

Home Phone _____Work Phone _____E-mail address_____

Sex: M 1 F 1 Age_____ Birthdate_____ Single 1 Married 1 Widowed 1 Divorced 1

Weight _____ Height_____

Employer _____Occupation _____

Business Address_____

Whom may we thank for referring you? _____

Primary Insurance

Person Responsible for Account_____
LAST NAME FIRST NAME MIDDLE INITIAL

Relationship to Patient_____ Birthdate_____ Soc. Sec. # _____

Address_____ Home Phone _____

Person Responsible Employed by_____ Occupation_____

Business Address_____

Insurance Company_____

Address_____

Phone_____Adjustor_____

Policy # _____ Group # _____ Effective Date_____

Insurance Type: HMO 1 PPO 1 ASHN 1 Worker's Comp 1 Auto 1 Other_____

Deductible $_____ Amount Met $_____Limitation on Visits_____ Copay $_____

Assignment and Release

I, the undersigned certify that I (or my dependent) has insurance coverage with_____
NAME OF INSURANCE COMPANY(IES)

and assign directly to _____ all insurance benefits, if any, otherwise payable to me for
NAME OF ACUPUNCTURIST

services rendered . I hereby authorize release of all information necessary to secure payment of benefits. I further authorize the use of my signature on all insurance submissions. If my health insurance company denies payment to the acupuncturist I understand that I am responsible to her for the full amount.

Signature:_____Date:_____

Health Profile

Date of last medical exam: _____ Who is your Doctor? _____ Phone # _____

Have you received acupuncture before? Yes No When? _____With Whom?_____

Please indicate any significant illnesses you or a blood relative (grandparent, parent or sibling) have had:

Illness	You	Your Relative	Approx. Date	Illness	You	Your Relative	Approx. Date
Cancer			_____	Diabetes			_____
Hepatitis			_____	Heart Disease			_____
High Blood Pressure			_____	Seizures/Epilepsy			_____
Hemophilia			_____	Emotional Disorders			_____
Infectious Diseases			_____	Tuberculosis			_____

Sexually Transmiitted Disease: Gonorrhea Syphilis AIDS HPV Chlamydia Herpes Date:_____

Do you have any prosthetic devices, pacemakers, metal pins, etc. in your body? Yes No

Explain:_____

List any medications and supplements you are currently taking: (Continue on back if necessary.)

Medicine	Dosage	Reason	How Long	Prescribed by:
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please indicate the use and frequency of the following:

	Yes	No	How Much?		Yes	No	How Much?		Yes	No	How Much?
Coffee/Black Tea	____	____	_____	Tobacco	____	____	_____	Water Intake	____	____	_____
Recreational Drugs	____	____	_____	Alcohol	____	____	_____	Soda Pop	____	____	_____
Exercise	____	____	_____	Relaxation	____	____	_____				

How do you feel about the following areas of your life?

	Great	Good	Fair	Poor	Your Comments:
Spouse or Significant Other					_____
Friends					_____
Career					_____
Quality of Life					_____
Sex					_____

What is the main problem/s for which you are seeking treatment?

(1)

(2)

Please rate the severity of your condition (on a scale of 1 to 10, 10 is the worst and 1 is the best):

How long have you had this health concern?

Is there any time of day or night in which your condition is worse?

What makes your condition better? (rest, heat, ice, etc.)

What makes your health concern worse? (exercising, certain movements, heat, cold etc.)

What other forms of treatment have you sought for this condition, when did you have these treatments, and were they helpful?

List in their order of priority any other health problems you have now:

(3)

(4)

(5)

(6)

List any allergies, food sensitivities or food cravings that you have.

List any accidents, surgeries, or hospitalizations (include date).

CLINICAL NOTES

(PHYSICIAN'S USE)

Onset Location Duration Characteristics Aggravate/Alleviate Related Factors Treatment Significance

EMERGENCY CONTACTS:

In case of an emergency, please contact:

1. Name:_____ Phone #s:_____

   Address:_____

2. Name:_____ Phone #s:_____

   Address:_____

3. Name:_____ Phone #s:_____

   Address:_____

CONFIDENTIAL FERTILITY QUESTIONNAIRE

Name:_____ Date:_____ Age:_____

Please answer the following questions to assist with your fertility. Note that this information is completely confidential. There are some very personal questions and if you feel uncomfortable, you can leave them blank.

Has your physician given you a reason for your infertility? If so, please explain:_____

_____

Have you ever been pregnant before? Yes No

Have you ever had any of the following?

Abortion Blighted Ovum Miscarriage Chemical Pregnancy

Do you have any children? If so, how many and how old are they?_____

Vaginal Birth/s C-Section

FERTILITY HISTORY

1. How long did you try to get pregnant naturally?_____
2. Have you had any of the following tests or surgeries? (Please circle one.) Hysterosalpingogram
   Fibroid Removal Cyst Aspiration Tube Removal Ovary Removal
3. Have you had any of the following conditions? Fibroids Ovarian Cysts Blocked Tubes
   Endometriosis Fibromyalgia Lupus Chronic Fatigue Syndrome
   Lacking Anti-Coagulant in Blood
4. Has your husband been examined by a physician? Yes No
   a. Were any of the following problems found?
      Low sperm count Poor morphology Sperm unable to penetrate egg Varicocele
5. Are you going to be having any medical procedures performed? (Circle one)
   IVF Frozen Embryo Transfer IUI
   If so, approximately when?_____
6. Have you had any of the following procedures previously? (Please circle and list date/s.)
   IVF _____ Frozen Embryo Transfer_____
   IUI_____
   _____ _____ _____
7. Are you currently on any infertility medications? Please list:_____
   _____
8. Have you ever tested positive for hypothyroidism or hyperthyroidism? Yes No
9. How many days is your cycle (i.e., 28 days):_____
10. How long is your menses? (i.e., 5 days):_____
11. Please circle the description of your menstrual flow?

	Light	Medium	Heavy
a. Day 1			
b. Day 2			
c. Day 3			
d. Day 4			
e. Day 5			
f. More than 5 Days			

12. What color is the blood of your menstrual flow?
    Light, watery red Bright red Dark Red Brown Clots
13. Do you have pain during intercourse? Yes No
14. Do you get PMS? Yes No List your primary symptoms:_____
    _____

15. Do you get cramps on your period? If so, what day/s?_____
16. Have you ever had an abnormal pap smear? If so, when, and how was it resolved?
_____
17. Do your breasts become tender before/during your period? Yes No
18. Do you have fibrocystic breast disease? Yes No Unknown
19. Have you ever had or do you currently have any breast lump/s? Yes No
If so, did you have any treatment for them?_____
20. Do you have a history of breast cancer? Yes No If so, please list who had breast cancer in your family:_____
21. Have you ever taken your basal body temperatures? Yes No
If so, what was your average temperature?_____
22, What do you do for relaxation?_____
23, Do you have high blood pressure? Yes No
24. Do you have any heart problems? If so, please describe:_____
25. How is your stress level? Low Stress Medium Stress High Stress
26. Do you exercise? If so, please list the type/s of exercise and how often. _____
_____
27. Have you had any counseling since trying to become pregnant? Yes No
28. Have you ever been molested or raped? Yes No

Thank you for your help in answering these questions. We look forward to working with you.